Specializing in both Oncology and Hematology

Please complete the questions on the following pages as best as you can and bring this form to your appointment.

This information will help us to understand who you are and what we can do to assist you during this experience.

You will review this form with a Nurse who will be able to answer any questions or concerns that you have and assist you with any areas that may be difficult to answer.

There is a team of professionals available to you and we are interested in helping both you and those people who are important to your life. Please do not hesitate to ask questions and take advantage of the services available through the Cancer Center.

Thank you,

The Staff of the C.R. Wood Cancer Center

Please check in at the Cancer Center Reception Desk on the 1st floor in the Pruyn Pavilion. For questions please call 518-926-6620.
Patient Name: _____________________________ Date of Birth: ________

Your Care Team:
Family Physician/PCP: ____________________________________________
Surgeon: ____________________________________________
Gynecologist: ____________________________________________
Other: ____________________________________________

Do you have any Allergies? □ yes □ no

ALLERGIES What type of reaction do you have?
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

Do you take any prescription or over the counter medication? □ Yes □ No
If yes, please list: Please include herbs & vitamin supplements

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>DOSE</th>
<th>FREQUENCY</th>
<th>REASON</th>
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List your past health history with dates (illness/problems, surgeries, injuries):

Illness or Problem/Date: Surgery/Date: Injury/Date:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

If applicable, please list date of last: Colonoscopy: ______________________ Mammogram: __________________ PAP Smear: __________________
**Family History**

Following is a list of questions regarding your family members. It is important for us to get as much information as possible, especially concerning any cancer or blood related problems in your family. List all family members, regardless of whether they have any health concerns. Please include any information that is known to you. For information that you are not sure of, it may be helpful to ask other family members. Please write unknown if you do not know the answer to a question. Remember, what may not seem important to you could be very important to us. (Examples of other conditions: high blood pressure, heart problems, breathing difficulties, seizures, mental retardation, stroke, eye problems, etc.)

<table>
<thead>
<tr>
<th>Relative</th>
<th>Cancer or blood related problem (Answer Yes or No; what type? list all if more than one problem)</th>
<th>Age at Diagnosis</th>
<th>Other Illnesses or Medical Conditions** (Yes/No: what type of condition?)</th>
<th>Death (Yes/No) Cause &amp; Age</th>
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<td>Parents:</td>
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<td>Father</td>
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<td>Mother</td>
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<td>(names and ages)</td>
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<td>Brothers:</td>
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<td>Sons/Daughters:</td>
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<td>Grandparents, aunts, uncles, first cousins)</td>
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<td>(names and ages)</td>
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Social History:
Do you currently smoke? □ Yes □ No  If yes, how long have you smoked? _____ # years
Have you ever smoked? □ Yes □ no  If yes, when did you stop? _____ # years ago
What do/did you smoke and how much per day?
   cigarettes: □ yes □ no ________ per day □ currently
   cigars: □ yes □ no ________ per day □ currently
   pipe: □ yes □ no ________ per day □ currently
   chew: □ yes □ no ________ per day □ currently

Do you drink alcohol (wine, beer or liquor)? □ Yes □ No
   If yes, how often do you drink and how much do you drink?
      □ daily _____drinks □ weekly _____drinks □ occasional

Do you use recreational drugs? □ Yes □ No  If yes, list ____________________________

Do you have a history of drug or alcohol abuse? □ Yes □ No

Home/Environment:
Are you: □ married □ single □ divorced □ widow(er)
Do you live: □ alone □ with spouse □ with family □ other ________________________________
Do you have any type of homecare services that you use: □ yes □ no
   If yes, please list: ________________________________________________________________
Do you have any type of homecare equipment that you use: □ yes □ no
   If yes, please list: ________________________________________________________________
Do you need assistance with Activities of Daily Living □ yes □ no

Psychosocial:
Are there religious, spiritual, or cultural beliefs that are important to you? □ yes □ no
   If yes, please explain: __________________________________________________________________

Do you feel you have a lot of stress in your life? □ yes □ no
   If yes, what things are causing stress for you? __________________________________________________________________

Are you working: □ yes □ no □ retired
   If yes: □ full time □ part time Where? ______________________________
      What is your occupation? _____________________________________________
   If no, do you plan to return to work? □ yes □ no □ unsure at present
Have you been exposed to hazardous materials?  □ yes  □ no
   If yes, what type?  ____________________________________________
   For how long?  _______________________________________________

Do you exercise on a regular basis?  □ yes  □ no
   If yes, how often?  □ 1-2 times/week  □ 3-4 times/week  □ 5-6 times/week  □ Daily
   Activity  □ Walking  □ Aerobics  □ Running  □ Swimming  □ Weight lifting  □ Yoga
   □ Other:  ____________________________________________________

Check if you have noticed a change in your energy level when:
   □ eating  □ walking  □ bathing  □ doing housework
   □ shopping  □ dressing  □ cooking  □ doing hobbies
   Are any of these new?  □ yes  □ no  If yes, which ones?  ________________________________

Check if you are experiencing any problem with sleep:
   □ difficulty falling asleep  □ do not feel rested after sleeping
   □ difficulty staying awake  □ usually feel rested after sleeping
   □ Other sleep related problems:  ______________________________________
   Describe / write a list of what helps you sleep:  ______________________________

Sexuality/Reproductive:
Are you sexually active?  □ yes  □ no
Are you and your partner currently any using birth control?  □ yes  □ no
   If yes, what method?  □ pills  □ IUD  □ condoms  □ diaphragm  □ patch  □ rhythm
   □ Tubal ligation  □ vasectomy  □ other (specify)  ________________________________
Do you have any concerns about fertility preservation?  □ yes  □ no
Often people diagnosed with cancer have some concerns regarding sexual activity or sexuality; do
you have any such concerns?  □ No  □ Yes (specify)  ________________________________

Female Specific:
Do you now or have you ever taken any Hormones such as estrogen, birth control pills or
injections?  □ yes  □ no  If yes, what type:  ________________  # of years used:  __________
Do you have any of the following breast symptoms?  If yes, please check:
   □ Fibrocystic Disease  □ Tenderness  □ Nipple Discharge  □ Masses  □ Other:  ________
Do you know how to perform a self-breast exam?  □ yes  □ no
Do you perform breast self-exams?  □ yes  □ no
Would you like to learn how to perform a self-breast exam?  □ yes  □ no
Do you have any unusual vaginal discharge?  □ yes  □ no
Do you have any concerns about changes in your body?  □ yes  □ no
Number of Pregnancies _____  Number of Live Births _____  Age of first live birth: ______
Menstrual History:

Menstrual Status: ☐ Menopausal ☐ Post-Menopausal Last Menstrual Period: _______

Age of First Period: ______ Frequency: _______ Length: _______

Age of Last Period: _______

Description of Menstruation: ☐ Amenorrhea ☐ Dysmenorrhea ☐ Irregular ☐ Menopausal
☐ Missed periods ☐ Normal ☐ Post-menopausal ☐ Prior Abnormal ☐ Other: ___________

Male Specific:

Have you had a vasectomy? ☐ yes ☐ no If yes, reason: ________________________________

Do you have the any of the following symptoms? If yes, please check:

☐ History of infection ☐ Penile Discharge ☐ Penile Lesions
☐ Testicular Pain ☐ Testicular Swelling ☐ Other: _______________

Do you perform self-testicular exams? ☐ yes ☐ no

Would you like to learn how to perform a self-testicular exam? ☐ yes ☐ no

Transfusion History:

Have you ever received a blood or blood product transfusion: ☐ Yes ☐ No

If yes, did you have an adverse reaction? ☐ Yes ☐ No

If yes, check type of reaction: ☐ Bloody Urine ☐ Chills ☐ Fainting/Dizziness ☐ Fever
☐ Flank Pain ☐ Hives ☐ Rash ☐ Other ________________________________

Is a blood product transfusion acceptable to you if needed? ☐ Yes ☐ No

Are there any restrictions? ☐ Yes ☐ No If yes, list: ________________________________

Do you have a history of bleeding problems: ☐ Yes ☐ No

If yes, list details: ________________________________________________________________

Hematology History: **Complete only if you have had problems with blood clotting in the past**

Do you have a history of clotting problems: ☐ Yes ☐ No

If yes, list details: _______________________________________________________________

Do you think you have a tendency to develop abnormal blood clots: ☐ Yes ☐ No

If yes, when did this begin _______________________________________________________

Please describe the circumstances: _________________________________________________

Have you had any of the following prior to developing a clot: ☐ Surgery/Procedure ☐ Trauma
☐ Hospitalized ☐ Pregnancy ☐ Oral Contraceptive Use ☐ Estrogen Replacement Use
☐ Cancer ☐ Air Travel ☐ Car trip over 4 hours ☐ Bed rest longer than 4 days

Long Term effects of blood clots: ☐ Leg pain at rest ☐ Leg pain w/walking ☐ Leg cramps at rest
☐ Leg cramps w/walking ☐ Leg swelling ☐ Leg swelling that varies by time of day
☐ Discoloration of legs ☐ Leg ulcers ☐ Limitations in: recreational activities, work or self-care
Check if you are experiencing any of the following:
Respiratory: □ Shortness of Breath □ Cough
Comment:____________________________________
Cardiovascular: □ Chest Pain □ Palpitations □ Dizziness □ Swelling
Comment:____________________________________
Gastrointestinal: □ Abdominal Pain □ Nausea □ Vomiting □ Constipation □ Diarrhea
□ Bloating □ Blood in Stool □ Hemorrhoids □ Up at night to go
Date of your last Bowel Movement: ____________
Comment:____________________________________
Genitourinary: □ Dribbling □ Burning □ Pain □ Trouble starting to go □ Frequency
□ Blood in urine □ No control □ Up at night to go (# of times ____)
Skin: □ Bruising □ Change in skin color □ Itching □ Rash □ Lesion
Comment:____________________________________
Neurological: □ Hearing □ Seizures □ Smell □ Speech □ Confusion/Disorientation
□ Dizziness □ Drowsiness □ Faintness □ Headache □ Numbness □ Tingling
□ Visual changes □ Weakness □ Other
Comment:____________________________________
Neuromuscular: □ Joint Stiffness □ Joint Swelling □ Numbness □ Tingling □ Weakness
□ Other Comment:____________________________
Do you have a Central Venous Access Line: □ Yes □ No
If yes, list type, location and insertion date: _______________________
Have you ever been treated with radiation therapy? □ Yes □ No
If yes, please describe: _______________________________________
Are you currently using any methods of cancer treatment? □ Yes □ No
If yes, what methods?_________________________________________
Do you have a prescription plan? □ Yes □ No
If yes, who is your plan with? _________________________________
Dental Health: Who is your dentist? ________________________
When was your last dental exam? ____________
Do you have any loose teeth? □ Yes □ No
Do you have dentures? □ Yes □ No
If yes: □ Upper □ Lower □ Partial
Are you having any dental problems? □ Yes □ No
If yes, list: _____________________________________________
Diet and Nutrition:
Have you had any weight change in the last 3 months? □ Yes □ No
If yes, number of pounds ____________ □ lost □ gained
Check the word(s) that describe your diet:
¨ regular ¨ liquid ¨soft ¨diabetic ¨ pureed ¨ other ______________________
Check if you are experiencing any of the following: □ Loss of appetite □ Nausea □ Vomiting
□ Metallic taste □ Indigestion □ Mouth sores □ Difficulty swallowing □ Difficulty chewing
□ Other:_____________________________________________
Are any of these new? □ Yes □ No
If yes, which ones? □ Loss of appetite □ Nausea □ Vomiting □ Metallic taste □ Indigestion
□ Mouth sores □ Difficulty swallowing □ Difficulty chewing □ Other
Sensory:
Do you wear: □ Glasses □ Contacts □ Hearing Aid(s)
Do you have a history of: □ Cataracts □ Glaucoma □ Other ______________________________
Who is your eye doctor: ____________________ Date of last eye exam: ____________________

Psychosocial:
Do you feel like you have a lot of stress in your life? □ Yes □ No
In the last year, have there been any major events in your life besides your illness? □ Yes □ No
   If yes, please explain: ____________________________________________________________
Are you currently seeing a counselor or psychologist? □ Yes □ No
   If yes, who are you working with: ________________________________________________
Are you interested in talking with a counselor for support or help coping with your illness?
   □ Yes □ No
Is anyone in your family interested in speaking with a counselor? □ Yes □ No
Have you had experience with cancer in the past? □ Yes □ No
What concerns you most about your health problem? ______________________________________

Do you have an Advanced Directive? □ Yes □ No Date Signed: _______________________
   If yes, what type: □ Durable Power of Attorney □ Health Care Proxy □ Living Will
   □ Extended Care Facility DNR □ Nonhospital DNR □ MOLST □ Other ____________________
   What is the name of Power of Attorney or Health Care Proxy? _______________________

** Please bring a copy with you if it is not already on file at Glens Falls Hospital**
If you do not have an Advanced Directive, would you like information about it? □ Yes □ No

Fall Risk:
Have you fallen 2 or more times in the last 12 months? □ Yes □ No
   If yes, were you injured? □ Yes □ No Please explain: ___________________________________

Patient Signature: __________________________________ Date: ________________

Nurse Signature: __________________________________ Date: ________________